Services available to the institutionalized Medically Needy for which no Federal Financial Participation (FFP) is claimed by the state are:

For residents in an intermediate care facility or a skilled nursing facility;

1. Dentists' services,
2. Optometrists' or opticians' services,
3. Chiropractors' services,
4. Eyeglasses, and
5. If prescribed by a physician,
   a. Medical day treatment and other mental health services and
   b. Nursing services.

HCFA-179 # 86-0011 Date Rec'd 5/7/86
Supercedes NONE Date Appr. 5/16/86
State Rep. In. _____ Date Eff. 4/1/86

Supplement 1 to Attachment 3.1-B
State: Wisconsin

DESCRIPTION OF LIMITATIONS

1. Eff. 4-1-93 Inpatient Hospital Services. Prior authorization is required for services provided outside the state by non-border status providers in non-emergency circumstances, for transplant services and for ventilator dependent services. Other professional services that require prior authorization outside the hospital, often require prior authorization when provided in a hospital.

Other limitations include, but are not limited to: circumstances for private room accommodations; restrictions on non-therapeutic sterilizations; requirements for separate billing of independent professional services; and restrictions to avoid duplicative and unnecessary payments.

2.a. Outpatient Hospital Services. Prior authorization restrictions apply to these services as required by the area of service.

2.b. Rural Health Clinic Services. Services provided by rural health clinics are subject to the same prior authorization requirements and other limitations as applied to covered services in the Medical Assistance Program.

4.a. Skilled Nursing Facility Services. Prior authorization is required for rental or purchase of a specialized wheelchair. Levels of service required are stipulated by the recipient's plan of care, subject to guidelines described in HSS 107.09(3).

4.c. Family Planning Services. Sterilization procedures require prior authorization and informed consent as mandated under federal regulations.

5. Eff. 4-1-93 Physician's Services. The Department imposes some payment and benefit limitations on some specific physician services. Many of these limitations are based on quantity and frequency, diagnoses, provider specialty, or the place the service is provided. In addition, some procedures require prior authorization and/or a second surgical opinion. Examples of physician services in each of these areas are listed below:

Services with Quantity and Frequency Limitations - Services with quantity and frequency limitations include: evaluation and management visits in the office, outpatient clinic and inpatient hospital nursing home; routine foot care; specific injections; weight alteration programs; fetal monitoring; clozapine management, and multiple surgeries performed on the same day.

TN #93-019
Supersedes
TN #93-003

Approval Date 8-02-93 Effective Date 4/1/93

CH03193.MP/SP

Services with Diagnosis Limitations - Services with diagnosis limitations include: certain injections, routine foot care and application of Unna boots.

Services with Provider Specialty Limitations - Provider specialty limitations are imposed on physicians providing obstetric and podiatric services, and those performing evoked potentials testing.

Services with Place of Service Limitations - Place of service limitations are imposed on medication management in the home and on critical or prolonged care provided in the emergency department.

Services that Require Prior Authorization - To insure that a procedure is medically necessary, to demonstrate that the procedure is not primarily cosmetic or for the convenience of the recipient, to assure that the procedure is not experimental in nature, and to allow the Department to determine the treatment is the most cost-effective available, the provider must obtain prior authorization for the following categories of procedures:

1) Surgical or other medical procedures of questionable medical necessity but deemed by the Department to be essential to correct conditions that cause significant impairment to the recipient's interpersonal adjustments or employability;

2) Surgical procedures or medical procedures that the Department deems redundant, outdated or marginally effective;

3) Transplants;

4) Sterilizations (to conform with federal and state regulations and limitations);

5) Temporomandibular surgery.

Second Surgical Opinion - Elective surgeries that require the recipient obtain a second surgical opinion include but are not limited to: cataract extraction; cholecystectomy; hemorrhoidectomy; diagnostic D & C procedures; inguinal hernia repair; hysterectomy; joint replacement, hip or knee; tonsillectomy/adenoidectomy; varicose vein surgery.

5.b. Eff. 10-1-91 — Dental Services. The same prior authorization and other limitations required under item #10 and 12.b. apply.

6.a. Eff. 7-1-90 — Podiatry Services. Prior authorization is required for electric bone stimulation. Maintenance care is limited to once per 61 day period under certain conditions. For other service limitations, see s. HSS 107.14(3), Wis. Admin. Code. All orthopedic and orthotic services, including repairs, orthopedic and corrective shoes and supportive devices, services correcting "flat feet," and treatment of subluxation of the foot are not covered.

6.b. Eff. 1-1-93 — Vision Care Services. (Optometry) Prior authorization is required for certain types of lenses and frames, antisciknic services, prosis crutch services, low vision services, certain ophthalmological services and vision training. Frames, lenses and replacement parts must be obtained through the volume purchase plan provider, unless prior authorized. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

6.c. Eff. 3-1-86 — Chiropractic. Prior authorization is required for services beyond the initial visit and 20 spinal manipulations per spell of illness. Consultations are not covered.

6.d. Eff. 4-1-93 — Other Practitioners

Other Nurse Practitioners and Clinical Nurse Specialist Services. Included are other primary care nurse practitioner and clinical nurse specialist services not covered under item #23. Services are subject to limitations imposed on specific disciplines within the scope of practice of the nurse. These services include medical services delegated by a licensed physician through protocols, pursuant to the requirements set forth in the Wisconsin Nursing Act and the guidelines set forth by the medical examining board and the board of nursing. Other practitioner services are subject to the same limitations imposed on physician services under item #5 to enable the Department to monitor and regulate the following: medical necessity, cost, frequency and place of service.

Medication management includes in-home administration of medications other than those given intravenously, prefilling syringes for self injection when the recipient is not capable, setting up medications for self-administration, and programming dispensers. Instructing the recipient may be covered when provided in conjunction with these activities but not covered if it is the only activity.

10. Eff. 10-1-95 Dental Services. Dental services are limited to the basic services within each of the following categories: diagnostic services, preventive services, restorative services, endodontic services, periodontic services, fixed and removable prosthodontics, oral and maxillofacial surgery services, and emergency treatment of dental pain. The following are examples of services not covered: dental implants and transplants; services for cosmetic purposes; overlay and duplicate dentures; precious metal crowns; professional visits; drug dispensing; adjunctive periodontal services; alveoplasty and stomatoplasty; and non-surgical temporomandibular joint therapy. Several services are provided only in specified circumstances or as referred through a HealthCheck (EPSDT) screen. For other limitations and a listing of those services requiring prior authorization, see the WMAP Dental Provider Handbook, Part B.

11. Eff. 7-1-88 Physical Therapy and Related Services. Prior authorization is required for physical and occupational therapies, and speech pathology after 35 treatment days per spell of illness. (See HSS 107.16(2) through .18(2), Wis. Administrative Code). Services for recipients who are hospital inpatients or receiving therapy through a home health agency are not subject to this requirement. For audiology, prior authorization is required for speech and audiotherapy, aural rehabilitation and dispensing of hearing aids. See HSS 107.19.

12.a Eff. 7-1-93 Prescribed Drug Products. All Schedule III and IV stimulant drugs as listed in the Wisconsin Medical Drug Index, enteral and parenteral nutrition products, and certain other drug products entailing excessive cost or utilization require prior authorization. Other limitations apply to the frequency of dispensing certain drug products. General categories of over-the-counter drug products which are covered are: antacids, analgesics, insulins, contraceptives, cough preparations, ophthalmic lubricants, and other medically necessary, cost effective drug products including some non-legend products that previously had legend drug status.

Payment will be restricted to only those drug products supplied by manufacturers that have a signed federal rebate agreement or an approved existing agreement when required by federal law.

Drugs or classes of drugs or medical uses restricted by state option:

1. N/A

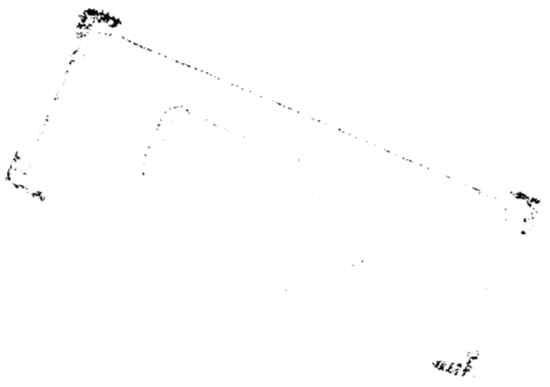
12b. Dentures. Prior authorization is required.

12.c Eff. 1-1-93 Prosthetic Devices. Prior authorization is required for most prosthesis, hearing aids and other medical equipment in the Wisconsin Durable Medical Equipment and Supplies indices, except for certain ophthalmological prostheses. Prior authorization also is required for most items not in the indices.

12.d Eff. 1-1-93 Eyeglasses. When frames and lenses services are provided by the same provider, prior authorization is required to exceed the following limitations in a 12 month period: one original pair; one unchanged prescription replacement pair; and one replacement pair with a documented changed prescription meeting Department criteria. Tinted lenses, occupational frames, certain glass and lens types and frames and other vision materials not obtained through the volume purchase plan also require prior authorization. Anti-glare coating, spare eyeglasses and sunglasses, and services provided primarily for convenience or cosmetic reasons are not covered.

13.d Eff. 1-1-93 Rehabilitative Services.

Community Support Program Services. Community Support Programs (CSP) provide a compendium of medical and psychosocial/ rehabilitative services, enabling the recipient to better manage the symptoms of his/her illness, to improve independence, and to achieve effective levels of functioning in the community. Recipients able to benefit from mental health treatment and restorative services provided in a community setting on a long-term basis will experience a reduction in the incidence and duration of institutional care they might otherwise need.



An MA recipient who is eligible for these services has a diagnosed, severe long-term illness which puts the person at significant risk of continued institutionalization. The recipient is seriously impaired in the basic areas of everyday functioning, and traditional mental health outpatient treatment on a regular basis for at least a year has proven ineffective.

Agencies providing MA CSP services must be certified by the Department of Health and Social Services. Certification requires that direct supervision of treatment staff providing services is performed by a clinical coordinator who has appropriate education and clinical experience with long-term mentally ill persons; a psychiatrist must be available to provide direction and necessary psychiatric services; an in-depth assessment is completed within 30 days; and a comprehensive treatment plan is developed and reviewed at least every six months.

Services are focused on increasing the recipient's ability to gain and maintain normal functioning in the community and at home. Following in-depth assessment and mental health treatment planning, rehabilitative treatment and activities are structured to ameliorate the effects of illness on the recipient's ability to perform personal care and social activities of every-day living. Restorative care is provided to enable the recipient to seek and maintain employment; to obtain necessary medical, legal, financial and governmental services; and to acquire and maintain adequate housing. In addition, a medical treatment component affords family, individual and group psychotherapy, medication administration and monitoring, 24-hour crises intervention, and ongoing psychiatric and psychological evaluation. Finally, community support program services include case management ongoing monitoring and service coordination activities. The majority of psychosocial/rehabilitative treatment activities as well as medical treatment is provided in the community or the recipient's home to afford maximum support for the recipient in meeting treatment goals.

CSP services may include Clozapine management. See description under 6d. Other Practitioners.

Eff. 7-1-95

School Based Services

Benefits and Limitations

Special rehabilitation services are evaluative, diagnostic and treatment services to correct any defects or conditions, or to teach compensatory skills for deficits that directly result from a medical condition. These services include obtaining, interpreting, and integrating evaluative, diagnostic and treatment information appropriate to an individual's coordinated plan of care. Special rehabilitation services may be provided under the provisions of the Individuals with Disabilities Education Act (IDEA) and are reimbursable only when included in and after implementation of an IEP (Individualized Education Plan) or IFSP (Individualized Family Service Program) under IDEA. Treatment services must be prescribed or referred by a physician, a licensed Ph.D. psychologist, or an advance practice nurse with prescriptive authority as allowed within their scope of practice.

Controls to prevent duplicate services and assure continuity of care are established by Medicaid where a child receives services from both Medicaid certified School Based Services (SBS) providers and Medicaid Health Maintenance Organizations (HMOs) or fee-for-service providers.

For example, where a child enrolled in a Medicaid HMO receives SBS services, the HMO is responsible for providing and managing medical services. School based medical services are not included in Medicaid's capitated payment to HMOs. Effective with implementation of the new managed care contract, SBS and HMO providers will be required to sign joint Memorandums of Understanding (MOUs), a legal document setting standards, policies and procedures to avoid duplication of services and coordinate care for the child. Where a child served by the Medicaid fee-for-service system receives SBS services, Medicaid requires SBS providers to document regular contacts between schools and community providers (such as physicians and therapists) as appropriate for each child but at least annually; and Medicaid will monitor service coordination and ensure duplicate services are not provided through prior authorization.

Special rehabilitation services include the following:

1. Speech, Language and Hearing: These are services for individuals with speech, language and hearing disorders that adversely affect the functioning of the individual. The services are provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. Services include evaluations and reevaluations to determine an individual's need for these services; recommendations for a course of treatment;

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IEP/IFSP case management; and the following services when identified in the IEP or IFSP: treatment; and medical equipment for use in both the home and school settings, solely for the use of one child, under utilization controls established by Medicaid. The equipment is owned by the recipient.

2. Occupational Therapy: This service is prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist as defined in 42 CFR 440.110(b). These services are rehabilitative, active, or restorative, and are designed to correct or compensate for a medical problem interfering with age appropriate functional performance. This service means evaluations and reevaluations of problems interfering with an individual's functional performance; recommendations for a course of treatment; IEP/IFSP case management; and the following services when identified in the IEP or IFSP: treatment; and medical equipment for use in both the home and school settings, solely for the use of one child, under utilization controls established by Medicaid. The equipment is owned by the recipient.

3. Physical Therapy: This service is prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist as defined in 42 CFR 440.110(a). These services are rehabilitative, active, or restorative, and designed to correct or compensate for a medical problem. This service means evaluations and reevaluations to determine an individual's need for physical therapy; recommendations for a course of treatment; IEP/IFSP case management; and the following services when identified in the IEP or IFSP: treatment; and medical equipment for use in both the home and school settings, solely for the use of one child, under utilization controls established by Medicaid. The equipment is owned by the recipient.

4. Nursing: This service is performed by a Registered Nurse or licensed practical nurse, or is a delegated nursing act under nursing protocols. The services are prescribed or recommended by a physician or advance practice nurse with prescribing authority and are included in the IEP or IFSP. The services are within the scope of professional practice of a Registered Nurse or licensed practical nurse, and includes but is not limited to: screening and referral for health needs; medication management; IEP/IFSP case management; explanations of treatments, therapies, and physical or mental conditions with family or other professional staff; and medical equipment for use in both the home and school settings, solely for the use of one child, under utilization controls established by Medicaid. The equipment is owned by the recipient.

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5. Psychological, Counseling and Social Work: These services mean diagnostic services or active treatments with the intent to reasonably improve the individual's physical or mental condition. These services are performed by a licensed physician or psychiatrist, or licensed or certified school psychologist, school counselor, or school social work staff. These services include but are not limited to: testing and evaluation that apprise cognitive, emotional and social functioning and self concept; recommendations for a course of treatment; IEP/IFSP case management; and therapy and treatment identified in an IEP or IFSP that is planning, managing, and providing a program of psychological, counseling or social work services to individuals with a diagnosis or evaluation of psychological or behavioral problems, and unscheduled activities for the purpose of resolving an immediate crisis situation. Treatment services must be prescribed or referred by a physician or a licensed Ph.D. psychologist, and are included in an IEP or IFSP.

6. Developmental Testing, IDEA Assessment and Reassessment, and Ongoing Monitoring and Coordination of IEP/IFSP Services: These services are performed by Director's of Special Education and/or Pupil Services, and other certified school staff within the scope of their certification. Developmental testing means testing performed to determine if motor, speech, language, hearing, and psychological problems exist, or to detect the presence of any developmental lags. IDEA assessments and reassessments are medical assessments that are evaluations, tests, case management required to develop the IEP or IFSP, and ongoing monitoring and coordination of IEP or IFSP services and related activities performed to determine if an individual is eligible under the provisions of IDEA. These services occur regularly in the determination of eligibility under IDEA and are related to the evaluation of the functioning of the individual. These services are reimbursable only after they result in the implementation of an IEP or IFSP.

7. Transportation: This service includes transportation to and from SBS provider sites for medically necessary services in vehicles adapted with a ramp or lift. This benefit is provided by a SBS provider, or contracted provider, to individuals whose medical needs require special accommodation for transport. The covered services and transportation must be included in an IEP or IFSP. This benefit is available for transportation to or from the medical service only on the same day that a covered Medical Assistance service is provided.

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